



Revocation of Request for Access to Records

Please type or print neatly; we are not able to process incomplete or illegible forms.

SECTION A: INDIVIDUAL'S INFORMATION

Last Name: _____ First Name: _____ MI: _____ Date of Birth: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Phone: (home) _____ (work) _____

SECTION B: STATEMENT OF REVOCATION

I revoke my previous authorization to the Laboratories Administration for disclosure of my protected health information (PHI) as described below:

I understand that this revocation of my authorization will NOT affect any action that the Laboratories Administration or others took in reliance on my authorization before they received this written notice of my revocation.

I understand that re-disclosure of any information released prior to this revocation may have already occurred or may occur in the future without my knowledge or consent; therefore, the privacy of my PHI may no longer be protected by law.

SECTION C: DESCRIPTION OF AUTHORIZATION REVOKED

I hereby revoke any and all authorizations to the Laboratories Administration to release my PHI to any third party.

I hereby revoke my authorization dated _____, which authorized the Laboratories Administration to release my PHI to: _____

SECTION D: INDIVIDUAL'S SIGNATURE

Printed Name: _____

Signature: _____ Date: _____

If this revocation is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Printed Name: _____

Printed Name of Personal Representative Signature: _____ Date: _____

Relationship to Individual: _____

Please return this form via fax to (443) 681-4501 or via email to mdlabs.recordsrequest@maryland.gov